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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V8. A15ME
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09122

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9151 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover Trace</i>		c. LENGTH OF STAY IN 1b <i>8.0 A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>312 N Union St</i>		e. STREET ADDRESS <i>312 N. Union St</i>	
3. NAME OF DECEASED (Type or print) <i>Elizabcth</i>		First <i>A</i>	Middle <i>Ansalvich</i>
4. DATE OF DEATH <i>August 8 1959</i>		Last <i>1</i>	Month <i>Aug</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>10/19/1901</i>
9. AGE (in years at birthday) <i>57 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>
11. FATHER'S NAME <i>John A. Bradley</i>		12. CITIZEN OF WHAT COUNTRY? <i>Columbia Pa. U.S.A.</i>	
13. MOTHER'S NAME <i>Susan Goddard</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mr Wayne Keen, 101 Bloomsbury Ave</i>	
17. INFORMANT <i>Mr Wayne Keen, 101 Bloomsbury Ave</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic C V Disease</i>	
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i>		DUE TO <i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Columbia Pa. Pa. Pa.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Donald E Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <i>Donald E Palmer M.D.</i> DATE SIGNED <i>8-8-59</i>	
22a. BURIAL OR CREMATION, REMOVAL (Specify) <i>8/11/59</i>		22b. DATE THEREOF <i>8/11/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mr. Bethel</i>		22d. LOCATION (City, town, or county) (State) <i>Columbia Pa. Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald E Palmer, Hanover Trace, Pa.</i>		24a. REC'D BY REGISTRAR DATE AUG 13 '59	
ADDRESS <i>Donald E Palmer, Hanover Trace, Pa.</i>		24b. REGISTRAR'S SIGNATURE <i>Donald E Palmer</i>	

1910 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)
5M 9/55

9175 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		b. COUNTY <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Long Bay. Harb.</i>		d. STREET ADDRESS <i>Long Bay Harb.</i>	
3. NAME OF DECEASED (Type or print) <i>George</i>		First <i>Carl</i>	Middle <i>Ashford</i>
4. DATE OF DEATH <i>Aug 15 1959</i>		Month <i>Aug</i>	Day <i>15</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <i>Mar. 14, 1928</i>		9. AGE (In years last birthday) <i>31</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chemical Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shoe Factory</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Francis Ashford</i>		14. MOTHER'S MAIDEN NAME <i>Callie E. Shrader</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>223-30-9627</i>	
17. INFORMANT <i>Wm. Francis Ashford, Perryman, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> DUE TO <i>929.8</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pulled under by drowning by</i>	
20c. TIME OF INJURY Hour <i>7</i> a.m. Month, Day, Year <i>8-15-59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Long Bay Harbor Aberdeen Harb. Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Donald C. Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Ed. A. M. Ed</i> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <i>8-15-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/19/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Bakers Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>R.D. Aberdeen, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tanning</i>		ADDRESS Tanning Funeral Home Aberdeen, Md.	
24a. REC'D. BY REGISTRAR DATE <i>AUG 19 1959</i>		24b. REGISTRAR'S SIGNATURE <i>John G. Tanning</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09124

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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I M H X I V O 12 M 2		1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>nd</i> b. COUNTY <i>Harford</i>						
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X XXXXXXXX XXXX Perryman, Md.</i>		d. STREET ADDRESS <i>Maple Avenue</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
X S 13		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Tony Bar Harford</i>					d. STREET ADDRESS <i>XXXXX B XXXXX XXXX XXXX</i>						
		3. NAME OF DECEASED (Type or print) <i>Roy Allen</i>		First	Middle	Last	4. DATE OF DEATH <i>1944 10 15 59</i>		Month	Day	Year		
I 14		5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>October 8, 1944</i>		9. AGE (In years last birthday) <i>11 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
V 15		13. FATHER'S NAME <i>William Francis Ashford</i>					14. MOTHER'S MAIDEN NAME <i>Callie E. Shrader</i>						
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Wm. Francis Ashford</i>		Address <i>Perryman, Md.</i>					
O 16		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drinking</i> DUE TO 850X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell out of boat</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
M 20		20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. p. m. <i>10-15-59</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Tony Bar Bar Aberdeen Harford</i>		20f. (City or town) (County) (State)					
		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		22. ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>8-14-59</i>					
12 21		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/19/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Bakers Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>R.D. Aberdeen, Maryland</i>					
		23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring</i>		ADDRESS <i>Tarring Funeral Home Aberdeen, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 19 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Civilla S. Tamm</i>					

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

VS A15C 1-55 10-W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9177

09125

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY HARFORD CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN RURAL HAVRE DE GRACE		MARYLAND LENGTH OF STAY (In this place) 50 YRS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 2		STATE MD. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL HAVRE DE GRACE # 2 STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) Minnie CARROLL BAILEY		4. DATE OF DEATH Aug. 30 1959	
5. SEX FEMALE	6. COLOR OR RACE. WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH JULY 27 1865
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	9. AGE last birthday yrs. 94
13. FATHER'S NAME JOHN W. CARROLL		11. BIRTHPLACE (State or foreign country) MD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT & ADDRESS Mrs. BERTHA B. KNIGHT R. D. # 2		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		18. MEDICAL CERTIFICATION Cardiac Insufficiency Sensitivity	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-29-59, 1959, to 8-30-59, 1959, that I last saw the deceased alive on 8-29-59, and that death occurred at 7 P.M. from the causes and on the date stated above. SIGNATURE <i>D. L. Lewis M.D.</i> ADDRESS <i>111 Madison Street</i> DATE SIGNED <i>8/31/59</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF SEPT. 1 '59	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>		NAME OF CEMETERY OR Crematory ROCK RUN CEM.	
DATE SEP 1 '59		LOCATION (City, town, or county) HARFORD	
25. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell, HAVRE DE GRACE		ADDRESS MD	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9152

CERTIFICATE OF DEATH

Reg. Dist. No.

09126

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b 14 HRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
d. STREET ADDRESS Box 73		d. STREET ADDRESS Box 73	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First IRA	Middle J	4. DATE OF DEATH Brannan
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1899
9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Civil SERVICE	
10c. BIRTHPLACE (State or foreign country) PENNSYLVANIA		14. MOTHER'S MAIDEN NAME Abbie Thrush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-12-6539	
17. INFORMANT Malinda C. Brannan		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paraparesis right side -	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 30 hours -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Aug 1 - 1959 to Aug 5, 1959, that I last saw the deceased alive on Aug 4, 1959, and that death occurred at 12:45 M, from the causes and on the date stated above.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hopewell		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 - 1959 to Aug 5, 1959 , that I last saw the deceased alive on Aug 4, 1959 , and that death occurred at 12:45 M, from the causes and on the date stated above. ACTUAL SIGNATURE Clarence H. Benson, M.D.		22. ADDRESS (Street, city or town, state) Port Deposit, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leila Patterson alone		24a. DATE REC'D BY REGISTRAR AUG 10 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Kline			

WILLIAMSON COUNTY STATE DEPARTMENT OF HEALTH-BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9178

CERTIFICATE OF DEATH

Reg. Dist. No.

09127

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 24		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND			d. STREET ADDRESS Bayou Apartments Apt. A-2 Market Street		
3. NAME OF DECEASED (Type or print) REX WILLIAM BRITTON			4. DATE OF DEATH August 13 1959		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Aug 59	9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months 4 Days 9 IF UNDER 24 HRS. Hours 4 Min. 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Roy Leonard Britton			14. MOTHER'S MAIDEN NAME Betty Mae Bostedo		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None 17. INFORMANT Father		
Address Bayou Apts A-2 Havre de Grace, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity complicated with pneumonia DUE TO 763.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
INTERVAL BETWEEN ONSET AND DEATH 4 hours					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 13 August 1959 to 13 August 1959 that I last saw the deceased alive on 13 August 1959 , and that death occurred at 8:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>Thomas J Fraher</i>			M.D. US Army Hospital 13 Aug 59		
PHYSICIAN'S NAME (Type) THOMAS J FRAHER Capt MC			Aberdeen Proving Ground, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/59		22c. NAME OF CEMETERY OR CREMATORIAL Post Cemetery APG.	
22d. LOCATION (City, town, or county) (State) Aberdeen Prov. Gd., Md.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Tarring</i>			ADDRESS Tarring Funeral Home		24a. REC'D BY REGISTRAR CATHY S. THOMAS
					DATE AUG 18 '59

BY - COMPTON - HAN - HAN - HAN - HAN - HAN - HAN

CHARTER OF DEATH

750

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	80337	80338	80339	80340	80341	80342	80343	80344	80345	80346	80347	80348	80349	80350	80351	80352	80353	80354	80355	80356	80357	80358	80359	80360	80361	80362	80363	80364	80365	80366	80367	80368	80369	80370	80371	80372	80373	80374	80375	80376	80377	80378	80379	80380	80381	80382	80383	80384	80385	80386	80387	80388	80389	80390	80391	80392	80393	80394	80395	80396	80397	80398	80399	80400	80401	80402	80403	80404	80405	80406	80407	80408	80409	80410	80411	80412	80413	80414	80415	80416	80417	80418	80419	80420	80421	80422	80423	80424	80425	80426	80427	80428	80429	80430	80431	80432	80433	80434	80435	80436	80437	80438	80439	80440	80441	80442	80443	80444	80445	80446	80447	80448	80449	80450	80451	80452	80453	80454	80455	80456	80457	80458	80459	80460	80461	80462	80463	80464	80465	80466	80467	80468	80469	80470	80471	80472	80473	80474	80475	80476	80477	80478	80479	80480	80481	80482	80483	80484	80485	80486	80487	80488	80489	80490	80491	80492	80493	80494	80495	80496	80497	80498	80499	80500	80501	80502	80503	80504	80505	80506	80507	80508	80509	80510	80511	80512	80513	80514	80515	80516	80517	80518	80519	80520	80521	80522	80523	80524	80525	80526	80527	80528	80529	80530	80531	80532	80533	80534	80535	80536	80537	80538	80539	80540	80541	80542	80543	80544	80545	80546	80547	80548	80549	80550	80551	80552	80553	80554	80555	80556	80557	80558	80559	80560	80561	80562	80563	80564	80565	80566	80567	80568	80569	80570	80571	80572	80573	80574	80575	80576	80577	80578	80579	80580	80581	80582	80583	80584	80585	80586	80587	80588	80589	80590	80591	80592	80593	80594	80595	80596	80597	80598	80599	80600	80601	80602	80603	80604	8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9153

Item 2. See birth cert. et

CERTIFICATE OF DEATH

Reg. Dist. No.

09128

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ware de Grace</i>		c. LENGTH OF STAY IN lb <i>17 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cardiff</i>	
3. NAME OF DECEASED (Type or print) <i>Baby Boy</i>		d. STREET ADDRESS <i>—</i>	
4. DATE OF DEATH <i>8-22-59</i>		Month <i>8</i>	Day <i>22</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 21 1939</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George A. Cantler</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Hallan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>773.0</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>George A. Cantler</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE</i> DUE TO <i>HYALINE MEMBRANE DISEASE</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>10 HRS</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-21-59</i> to <i>8-22-59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8-22-59</i> , 19 <i>59</i> , and that death occurred at <i>Ware de Grace</i> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>—</i>			
DATE SIGNED <i>—</i>			
ACTUAL SIGNATURE <i>P.B. Neerman M.D.</i>			
PHYSICIAN'S NAME (Type) <i>—</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>8/23/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL Facilities <i>Harford Memorial Hospital</i>		22d. LOCATION (City, town, or county) (State) <i>Ware de Grace Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>—</i>		ADDRESS <i>Business Office</i>	
24a. REC'D BY REGISTRAR <i>Arthur L. Hause</i>		DATE AUG 25 '59	
24b. REGISTRAR'S SIGNATURE <i>—</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9154

CERTIFICATE OF DEATH

09129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Harford Maryland</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Han de Shore</i>		<i>Han de Shore</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
56 yrs		739 Ontario	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Mary</i>	<i>Flarity</i>	<i>Caprice</i>	<i>8/9/59</i>
4. DATE OF DEATH	Month	Day	Year
<i>8/9/59</i>	<i>8</i>	<i>9</i>	<i>19</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>7/4/1861</i>	9. AGE (In years lost birthday) 98 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>House Wife</i>	<i>none</i>	<i>Baltimore Md.</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Joseph G. Flarity</i>	<i>Catherine E. Dunn</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>No</i>	<i>XXXXXXXXXX</i>	<i>Emerson Mr. Wm. T. Heimiller, Han de Shore Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
422.2	DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.	(b)	<i>Cardiac Insufficiency</i>	
	(c)	<i>Hypertension</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>8/8</i> , 19 <i>59</i> , to <i>8/9</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8/8</i> , 19 <i>59</i> , and that death occurred at <i>Han de Shore</i> , M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED	
ACTUAL SIGNATURE	M.D.	<i>Harold A. Price, M.D.</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
	<i>8/12/59</i>	<i>Angel Hill</i>	<i>Han de Shore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
<i>Reverend Dr. Han de Shore</i>		<i>AUG 13 '59</i>	<i>Orline S. Kline</i>

WATERBURY STATE DEPARTMENT OF HIGHWAYS-67-1

CHARTER OF THE

WATERBURY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9155

CERTIFICATE OF DEATH

Reg. Dist. No.

109130

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Harford MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harde de Grace		c. LENGTH OF STAY IN lb 70 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen - 1514 Wheel Air Ave	
3. NAME OF DECEASED (Type or print)		First	Middle
AUGUSTA		S.	DILL
4. DATE OF DEATH		Month	Day
August 20		1959	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		white	8. DATE OF BIRTH Sept. 23, 1888
9. AGE (In years lost birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
70 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
10c. BIRTHPLACE (State or foreign country) Md.		11. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel J. Strode		14. MOTHER'S MAIDEN NAME Anna Marie O'Dougherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none	
17. INFORMANT no		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Coronary artery atherosclerosis (c)	
		INTERVAL BETWEEN ONSET AND DEATH 1 week	
		1-2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 3</u> , 1958, to <u>Aug 20</u> , 1959, that I last saw the deceased alive on <u>August 20</u> , 1959, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Aberdeen Md.	
ACTUAL SIGNATURE B. J. Blundell Jr.		DATE SIGNED 8-20-59	
PHYSICIAN'S NAME (Type)		22d. LOCATION (City, town, or county) (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/59	
22c. NAME OF CEMETERY OR CREMATORIAL Western Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Blundell & Sons - Baltimore		24a. REC'D BY REGISTRAR DUG 24 '59	
		24b. REGISTRAR'S SIGNATURE Orlent S. Thorne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9156

CERTIFICATE OF DEATH

Reg. Dist. No.

09131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Harford MARYLAND		Maryland Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
Harvee de Grace	15 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Harford Mem. Hospital	1 PO Box 293		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
Susie		Dorsey	Month Day Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 23, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		Home	Penna.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Thomas E. Wilson		Sarah Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Address Box 293 XXXX James Albert Dorsey, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Thrombosis	
260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Diabetes Mellitus	
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost.		(c) Hypertensive-Arteriosclerotic Heart disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/26, 1959, to 8/10, 1959, that I last saw the deceased alive on 8/10, 1959, and that death occurred at 9:50 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE George T. Stansbury, M.D. 29 Resolution St. Harvee de Grace, Md. 8/10/59			
PHYSICIAN'S NAME (Type) George T. Stansbury			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/59	
22c. NAME OF CEMETERY OR CREMATORIUM Fawn Zion Cemetery		22d. LOCATION (City, town, or county) (State) Fawn Grove, Penna	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring		ADDRESS Tarring Funeral Home Aberdeen, Md.	
		24a. REC'D BY REGISTRAR DATE AUG 17 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0132

MAY 1948

CITY OF BALTIMORE

STATE OF MARYLAND

CITY OF BALTIMORE

STATE OF MARYLAND

MAY 1948

Maryland
State SealBaltimore
City Seal

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9157

CERTIFICATE OF DEATH

09132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Manatee ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 N. Union Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradenton 48-X-3	
d. STREET ADDRESS 1801 38th. St. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER		First H.	Middle DOWLING
4. DATE OF DEATH August 13 1959	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1904
9. AGE (In years lost birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME James M. Dowling		14. MOTHER'S MAIDEN NAME Mary.C. Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-07-6376 17. INFORMANT Georgia Wagner	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4342 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		19. ADDRESS 403 Catherine Bel Air, Md. INTERVAL BETWEEN ONSET AND DEATH 15 months	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 8, 1959</u> , to <u>August 13, 1959</u> , that I last saw the deceased alive on <u>August 13, 1959</u> , and that death occurred at <u>118</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 N. Union Ave.			
ACTUAL SIGNATURE <i>Frank Wolbert, M.D.</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) Frank Wolbert, M.D.		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/59	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Tanning</i>		24a. ADDRESS Tanning Funeral Home Aberdeen, Md.	
		24b. REC'D BY REGISTRAR DATE AUG 18 '59	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	

STATE OF CALIFORNIA - DEPARTMENT OF STATE AUDITORS

CERTIFICATE OF DEATH

of JAMES D. GRIFFIN

DECEASED

on DECEMBER

1947

in the CITY OF SAN FRANCISCO

in the STATE OF CALIFORNIA

in the NAME OF

in the CITY OF SAN FRANCISCO

in the STATE OF CALIFORNIA

in the NAME OF

in the CITY OF SAN FRANCISCO

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in the STATE OF CALIFORNIA

in the NAME OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9158

CERTIFICATE OF DEATH

09133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Haure de Grace</i>		c. LENGTH OF STAY IN 1b <i>151 DAYS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Haure de Grace</i>	
3. NAME OF DECEASED (Type or print) <i>Florence</i>		First <i>Florence</i>	Middle <i>Elizabeth</i>
4. DATE OF DEATH <i>Aug. 23 1959</i>		5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JULY 27 1885</i>	
9. AGE (In years lost birthday) <i>74 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
12. IF UNDER 24 HRS. Hours <i>0</i>		13. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
14. MOTHER'S MAIDEN NAME <i>Annie Sampson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	
16. SOCIAL SECURITY NO. <i>212-16-0421</i>		17. INFORMANT <i>John Lubree 64271 Stokes St. son</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>(b)</i> DUE TO <i>(c)</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-18</i> , 19 <i>59</i> , to <i>8-23</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8-23</i> — 19 <i>59</i> , and that death occurred at <i>12:30</i> P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank D. Hauber</i>		ADDRESS (Street, city or town, state) <i>608 South Union Ave., Haure de Grace, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>Aug 26 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Run Cem</i>		22d. LOCATION (City, town, or county) <i>HARFORD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell Haure de Grace, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur & Trans</i>	
ADDRESS <i>Arthur & Trans</i>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 Item 18 Film 240 9-3-59 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09134

9178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 135		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford	
3. NAME OF DECEASED (Type or print) THOMAS		d. STREET ADDRESS Route 135	
4. DATE OF DEATH August 4 1959	Month Day Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1912
9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Paper	
11. BIRTHPLACE (State or foreign country) Martinsburg, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Fizer		14. MOTHER'S MAIDEN NAME Valley M. Keesee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 182-01-1305 Mrs. Katherine Fizer, Whiteford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Silicosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>W. Bradley King Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		DATE SIGNED 8/5/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Slateville		22d. LOCATION (City, town, or county) (State) Delta, York Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Hobson</i>		ADDRESS Delta, Pa.	
		24a. REC'D BY REGISTRAR DATE AUG 7 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

Herald C. Palmer

2113 Main St

Ree Ave, Md

1
X
FOR STATE
HEALTH DEPT.

9159 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09135

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

099

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>N. Y.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hame de Grace</i>		b. COUNTY	
c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New York City</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DO A Harford Memorial Hospital</i>		d. STREET ADDRESS <i>223 E 82nd St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month Day Year <i>August 8 1959</i>	
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i>		4. DATE OF DEATH Month Day Year	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>23 July 1926</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNK.</i>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>		12. CITIZEN OF WHAT COUNTRY? <i>FRANCE</i>	
13. FATHER'S NAME <i>ALEXANDE FUTTERSACK</i>		14. MOTHER'S MAIDEN NAME <i>GESTER LAZAR</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220</i>	
17. INFORMANT <i>MRS ELVIRA PALCSEY, FARMINGDALE, N.J. R.D. #1</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>825X</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i>		<i>Fracture Skull</i>	
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Auto accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>10 p.m. August 8, 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>15 Route 40</i>	
20f. (City or town) <i>Edgewood</i>		(County) <i>Harf.</i>	
		(State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <i>8-9-59</i>	
EXAMINER'S NAME (Type) <i>Gerald C. Palmer</i>		DATE SIGNED <i>Baltimore Md.</i>	
220. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>14 AUG 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell HAVER DE GRACE MO</i>		24a. REC'D BY REGISTRAR DATE AUG 14 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>C. L. C. & T. Inc.</i>	

STATE OF MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 20f: State Police

9180

CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bel Air Rural (Fountain Green)</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air Rural (Fountain Green)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hillside Road</u>		LENGTH OF STAY (in this place) <u>39 years</u>	
3. NAME OF DECEASED (First) <u>Ida</u> (Middle) <u>N.</u> (Last) <u>Graybeal</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Aug. 29, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 4, 1886</u>
9. AGE last birthday yrs. <u>73</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Grayson County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ephriam Boyer</u>		14. MOTHER'S MAIDEN NAME <u>Tabitha Tomlinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Wilbert M. Graybeal Rt. #1 Kingsville, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>180X</u> IMMEDIATE CAUSE <u>Cardio-Respiratory Failure</u> INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO <u>Metastatic Carcinoma</u> ONSET AND DEATH DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE <u>Carcinoma of the Left Kidney</u> <u>2 DAYS</u> STATING UNDERLYING CAUSE LAST. DUE TO <u>—</u> <u>1 1/2 YEARS</u> (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u> <u>2 YEARS</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		(State) <u>—</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>JUNE 24, 1949</u> , to <u>Aug. 29, 1959</u> , that I last saw the deceased alive on <u>Aug. 29, 1959</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>H. J. Biddle</u> ADDRESS (Street, city, town, state) <u>401 Franklin St. Bel Air, Md.</u> DATE SIGNED <u>3 Aug 59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 1, 1959</u> NAME OF CEMETERY OR CREMATORIUM <u>Mt. Zion Cemetery</u> LOCATION (City, town, or county) <u>Bel Air R.D. (Fountain Green) Harford Co., Md.</u> (State)	
24. REC'D BY REGISTRAR DATE <u>SEP 1 '59</u>		REGISTRAR'S SIGNATURE <u>Carroll S. Krause</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Trotter</u> ADDRESS <u>W. Broadway & W. 17th St., Bel Air, Maryland</u>	

STATE OF TEXAS - DEPARTMENT OF STATE PLANNING

CERTIFICATE OF DEATH

0810

DEATH CERTIFICATE

NAME OF DECEASED

ADDRESS

PHONE

AGE

SEX

CAUSE OF DEATH

DEATH DATE

DEATH TIME

DEATH PLACE

DEATH CITY

DEATH STATE

DEATH ZIP CODE

DEATH COUNTY

DEATH TOWN

DEATH ADDRESS

DEATH CITY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9160

CERTIFICATE OF DEATH

09137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
Harford MARYLAND		Md Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 24					
Harre-de-Grace		Harre-de-Grace					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION		d. STREET ADDRESS 1552 Sinclair ST.					
Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle				
Eva		Hawkins					
4. DATE OF DEATH		Month	Day				
Aug. 20		1959					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
Female Colored				March 10, 1893	66 yrs.	5 10	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House-wife				Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
Daniel Taylor.		Mary Raisin.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
no				None Florence Jenkins, Daughter		PULMONARY EDEMA 260X DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		Cerebrovascular accident hemorrhage.		10 minutes 1 week	
		(c)		Diabetes Mellitus & Atherosclerosis		54 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>August 20</u> , 1959, that I last saw the deceased alive on <u>August 20</u> , 1959, and that death occurred at <u>Harre-de-Grace</u> , Md., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <u>8/22/59</u>	
ACTUAL SIGNATURE <u>FRANK WOLBERT MD</u>							
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug. 24, 1959		22b. DATE THEREOF Aug. 24, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. James A.M.E. Cemetery		22d. LOCATION (City, town, or county) Harre-de-Grace Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ottilie J. Bullock, Harre-de-Grace Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR AUG 26 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur & Kuhn</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9161

CERTIFICATE OF DEATH

09138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Harford MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford-Grace		c. LENGTH OF STAY IN 1b 20 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pylesville	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS Newborn	
First Baby		Middle GIRL	Last Hess
4. DATE OF DEATH		Month 8	Day 30
		Year 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-29-59	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months 20	
		11. IF UNDER 24 HRS. Days 20	
12. CITIZEN OF WHAT COUNTRY? Maryland		13. FATHER'S NAME Henry Cecil Hess	
14. MOTHER'S MAIDEN NAME Betty Bodham		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Henry Hess, Pylesville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____		8/29, 1959 to 8/30, 1959	
alive on _____		and that death occurred at 4537 M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>S. H. H. S.</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/30/59	
22c. NAME OF CEMETERY OR CREMATORIAL Harford Memorial Hospital		22d. LOCATION (City, town, or county) Harford, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur - Harford Mem. Hosp.		24a. ADDRESS 24b. REC'D. BY REGISTRAR SEP 2 59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PMS. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9162 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Harford MARYLAND		Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 506 Maple View Drive		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air	
3. NAME OF DECEASED (Type or print) First: Charles Middle: Hinchie Last: Hinchie		d. STREET ADDRESS 506 Maple View Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month: August Day: 6 Year: 1959	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Mr 12 1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Austria		9. AGE (In years last birthday) 79 yrs.	
13. FATHER'S NAME MATTHEW HINCHIE		14. MOTHER'S MAIDEN NAME CECELIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES YES Spanish-American		16. SOCIAL SECURITY NO. 701-09-1807	
17. INFORMANT IMMEDIATE CAUSE (a) 420.1		Lt. Col. John C. Hinchie 506 MAPLE VIEW DRIVE T31 Air, Maryland	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Address INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald E Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8-6-59	
EXAMINER'S NAME (Type) Gerald E Palmer		22d. LOCATION (City, town, or county) St. Paul, (State) Minn.	
22b. DATE THEREOF August 19 1959		22c. NAME OF CEMETERY OR CREMATORIUM CALVARY CEMETERY	
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial		24a. REC'D BY REGISTRAR DATE AUG 12 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		24b. REGISTRAR'S SIGNATURE Cecilia S. Palmer	
ADDRESS W. Broadway and Williams St. BEL AIR, MARYLAND			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9163

CERTIFICATE OF DEATH

Reg. Dist. No. 09140

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Harford MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2 1/2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Harford Memorial Hospital '216 Baltimore P.K.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Norvel J.			Hodges
4. DATE OF DEATH		Month	Day
August 17		Year	1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH
Male		ce.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> October 3, 1909
8. AGE (In years last birthday)		9. IF UNDER 1 YEAR	10. IF UNDER 24 HRS.
49 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Minister		Methodist Church	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Louis Hodges		Ella Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		None	
17. INFORMANT		Address	
None Mrs. Virginia Hodges - Phila. 40, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hypoglycemia (Intractable)	
442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Hypertensive - Cardio renal disease	
DUE TO		(c) Poss. Islet Cell Neoplasm	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 10, 1959, to Aug. 17, 1959, that I last saw the deceased alive on Aug. 17, 1959, and that death occurred at 765 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE George T. Stansbury		M.D. 569 Revolution St. Harford, Md. 8/17/59	
PHYSICIAN'S NAME (Type) George T. Stansbury			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF	
Burial Aug. 21, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Henderson Hill Cemetery	
22d. LOCATION (City, town, or county) (State)		Bel-Air Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullard - Hause de Glace, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 19 '59		24b. REGISTRAR'S SIGNATURE Clyde S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9164 CERTIFICATE OF DEATH

Reg. Dist. No. 119141

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harde Grace</i>		c. LENGTH OF STAY IN 1b 70 ft.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 <i>Aberdeen</i>	
3. NAME OF DECEASED (Type or print) <i>Mary</i>		4. DATE OF DEATH 8 24 1959	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/29/1891</i>	
9. AGED (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Noah Preston</i>		14. MOTHER'S MAIDEN NAME <i>Eliza. Weers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Geo Henry Johnson Aberdeen 2nd.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 hr.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		Congestive Heart Failure <i>Hyperensive Heart Disease</i> 9 yr.	
(c) DUE TO		Essential Hypertension 9 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1950, 19 to 8-24-1959, that I last saw the deceased alive on 5-18-1959, and that death occurred at 2:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Peter P. Rodman, M.D.</i>			
PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/29/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Calvary Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>R.D. Aberdeen, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring</i>		ADDRESS Tarring Funeral Home Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE <i>AUG 31 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Thorne</i>	

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
CERTIFICATE OF OWNERSHIP

STATE POLICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9181

CERTIFICATE OF DEATH

Reg. Dist. No.

09142

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) US ARMY OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Army Chemical Center	
HOSPITAL ABERDEEN PROVING GROUND, MD		d. STREET ADDRESS 108 C Grant Court	
3. NAME OF DECEASED (Type or print) CHARLES E KIRTLEY		4. DATE OF DEATH August 26 1959	Month August Day 26 Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Edison Kirtley		14. MOTHER'S MAIDEN NAME Maria Garibay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT (If yes, give war or dates of service) None		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress syndrome DUE TO 773.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Prematurity DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH 12 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Edgewood (County) Md (State) Md	
21. I certify that I attended the deceased from August 25, 1959 , to August 26, 1959 , that I last saw the deceased alive on August 26, 1959 , and that death occurred at 9:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Fraher		ADDRESS (Street, city or town, state) AP6 Md DATE SIGNED 26 Aug 59	
PHYSICIAN'S NAME (Type) THOMAS J. FRAHER CAPT MC		US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Aug 28/59	
22c. NAME OF CEMETERY OR CREMATORIAL Army Chemical Center		22d. LOCATION (City, town, or county) Edgewood (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Tamm Aberdeen		24a. REC'D BY REGISTRAR DATE AUG 31 1959	
		24b. REGISTRAR'S SIGNATURE Charles S. Krause	

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9165 CERTIFICATE OF DEATH

Reg. Dist. No. 09143

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve de Grace		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS R.D. #1	
3. NAME OF DECEASED (Type or print) JOSEPHINE		First URSULA	Middle KOWALEWSKI
3. NAME OF DECEASED (Type or print) JOSEPHINE		Last KOWALEWSKI	4. DATE OF DEATH Month August
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 19, 1888		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Dominic Legachika		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-18-3030	
17. INFORMANT Peter J. Kowalewski, Aberdeen, Md.		Address R.D. 1, Box 200	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Thrombo phlebitis - it leg (c) Arterio occlusive VC Disease		3 wks 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 51 , to Aug , 19 59 , that I last saw the deceased alive on Aug 5 , 19 59 , and that death occurred at 8:00PM from the causes and on the date stated above. ACTUAL SIGNATURE J. Ralph Horky M.D. ADDRESS (Street, city or town, state) Churchville, Md. DATE SIGNED Aug. 7, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/59	
22c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Tarring		ADDRESS Tarring Funeral Home Aberdeen, Md.	
24a. REC'D BY REGISTRAR Arthur S. Krause		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

WILMINGTON STATE BANK - BALTIMORE, MD

STATE OF DELAWARE

1902

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

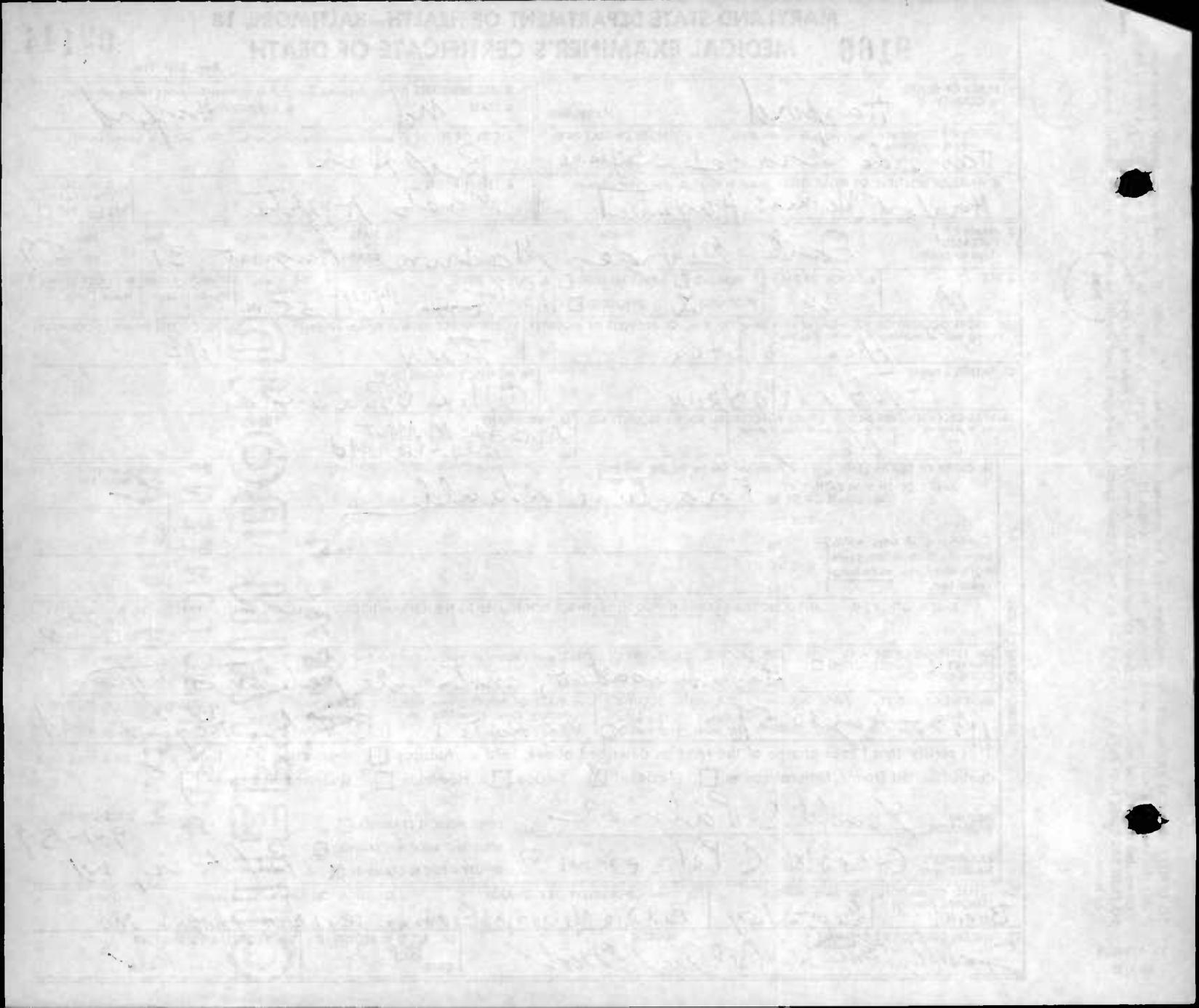
09144

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

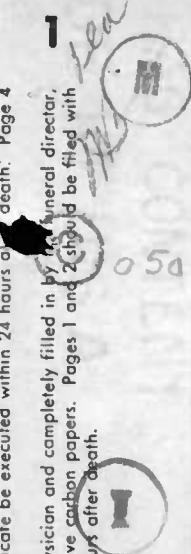
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Harford MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Name de Grace		35 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Harford Memorial Hospital		d. STREET ADDRESS	
e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Earl		Middle George	Last Madron
5. SEX		6. COLOR OR RACE	
M		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
D		9. AGE (In years last birthday)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House Painter		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Madron		Dollie Pease	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
812 X		Mrs. Edna M. Mast Bel Air Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Fracture skull		—	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO	
(b)		DUE TO	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS EXTERNAL CAUSE PRIMARY OR CONTRIBUTING CAUSE OF DEATH?	
Fracture skull		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
Harford accident, motorcycle-pedestrian type		20c. TIME OF INJURY Month, Day, Year	
1959 Aug 30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Bel Air Harford Md		Bel Air Harford Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		ACTUAL SIGNATURE	
Gerald C Palmer		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
Gerald C Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Sept 3/59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) (State)	
Bel Air Memorial Gardens		Bel Air Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Joseph Tipton Bel Air Md		Sep 3 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
Cathleen S. Kenna			
DATE			

188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9182

CERTIFICATE OF DEATH

Reg. Dist. No.

05145

1. PLACE OF DEATH a. COUNTY Harford				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MD				d. STREET ADDRESS 105 F South Court Road			
3. NAME OF DECEASED (Type or print) First Middle Marlow				4. DATE OF DEATH Aug. 1st 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years, last birthday) yrs. 12 months	
13. FATHER'S NAME Clyde Danforth Marlow				14. MOTHER'S MAIDEN NAME India Sheron Main			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Father		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary immaturity DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Prematurity (c)	
INTERVAL BETWEEN ONSET AND DEATH 12 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 July 1959 to 1 August 1959 that I last saw the deceased alive on 1 August 1959 , and that death occurred at 10:55 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) US Army Hospital Aberdeen Proving Ground, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Autopsy Seal		22b. DATE THEREOF 8/4/1959		22c. NAME OF CEMETERY OR CREMATORIAL Autopsy Board		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Farney		ADDRESS Aberdeen Proving Ground		24a. REC'D BY REGISTRAR DATE AUG 5 '59		24b. REGISTRAR'S SIGNATURE John G. Farney	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9167

CERTIFICATE OF DEATH

Reg. Dist. No.

19148

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRYMAN, I	
3. NAME OF DECEASED (Type or print) Lillian		d. STREET ADDRESS Mitchell's Farm	
4. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH August 28 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 7, 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Crump Davis		14. MOTHER'S MAIDEN NAME Addie Snowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Octavies Mc Dougal, Joppa, Maryland	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure & Cardiac Arrest 433.0 DUE TO to Cardiac Arrest	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-27 , 1959, to 8-28 , 1959, that I last saw the deceased alive on 8-28 , 1959, and that death occurred at 12:23 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 608 - S. Union Ave., Havre de Grace, Md.			
ACTUAL SIGNATURE Frank D. Hauber		DATE SIGNED 8-28-59	
PHYSICIAN'S NAME (Type) Frank D. Hauber		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Aug. 30 1959		22c. NAME OF CEMETERY OR CREMATORIAL Community Baptist	
22d. LOCATION (City, town, or county) Joppa, Harford, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McCombs		24a. REC'D BY REGISTRAR DATE SEP 2 '59	
ADDRESS Abingdon, Md.,		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09147

9168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTYHarford
MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Harve-de-Grace

c. LENGTH OF STAY IN 1b
31 hrs.d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATEMaryland
b. COUNTY

Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

New Port

Aberdeen

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
Aug.Day
26Year
1959

5. SEX

MALE

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

8/25/59.

9. AGE (In years
last birthday)

yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Infant

10b. KIND OF BUSINESS OR INDUSTRY

N/A

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James S. Rehrer Jr.

14. MOTHER'S MAIDEN NAME

Dorothy Ruby Davis

Address
Box 17615. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

N/A

17. INFORMANT

James S. Rehrer,

Aberdeen, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		78 hrs
762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Pulmonary astictans
(b) DUE TO		Pneumon
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY	Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/25, 1959, to 8-26, 1959, that I last saw the deceased alive on 8-26, 1959, and that death occurred at 4:30 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)
--	--	---------------------------------------

ACTUAL SIGNATURE	B.J. Plunkett, Jr.	M.D.	DATE SIGNED 8/26/59
PHYSICIAN'S NAME (Type)		B.J. Plunkett, Jr. M.D.	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	8/28/59	Grove Cemetery	Aberdeen, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
John H. Tassing	Tassing Funeral Home Aberdeen, Md.	AUG 31 '59	Carroll S. Kraus

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies, papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth

Date of Death

Name

Name

Name

Name

Name of Hospital or Institution

Name of Doctor

Name of Hospital

Name of Physician or Hospital

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9183

CERTIFICATE OF DEATH

19148

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Harford Edgewood	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Maryland Edgewood	COUNTY Harford
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) OF DEATH		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH July, 5, 1875	9. AGE last birthday 84 yrs.	Aug. 9, 1959 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant			10b. KIND OF BUSINESS OR INDUSTRY General Mdse.,	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS Emanuel G. Shapiro, Edgewood, Maryland.			18. MEDICAL CERTIFICATION Arteriosclerotic Cerebrovascular Disease Diabetes Mellitus		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260x IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6/27, 1957, to 8/7, 1957, that I last saw the deceased alive on 8/8, 1957, and that death occurred at 2 A.M. from the causes and on the date stated above. SIGNATURE <i>E. Louis Fahan</i> M.D. ADDRESS (Street, city, town, state) <i>Edgewood</i> DATE SIGNED <i>8/10/57</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 12, 1959		NAME OF CEMETERY OR CREMATORIUM Loudon Park	
24. REC'D BY REGISTRAR DATE AUG 13 '59		REGISTRAR'S SIGNATURE <i>Carling S. Krause</i>		LOCATION (City, town, or county) Baltimore	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Abingdon, Maryland.		ADDRESS Abingdon, Maryland.			

BY BROMWICH-NEW HAMPSHIRE STATE GUARANTEE

CERTIFICATE OF DEATH

John D. Smith

Deceased on November 20, 1910

Brookline

Mass.

Resident

Brookline

Deceased

Mass.

Resident

Brookline

John D. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9169

CERTIFICATE OF DEATH

09149

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		Maryland			
HARFORD		MARYLAND		Maryland		HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
HARFORD GRANGE		41 days		32 BEL AIR, MD		Mast Apt -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		HARFORD MEMORIAL HOSPITAL		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
ELIA		Rebecca	Stoker		August	4	1959		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
Female		White		April 19, 1906	53 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Checker		Woolworth 5+10 Store		Virginia		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
William H. Stoker		Ady F. FUNK							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT (SISTER)		Address			
NO		212-22-3210		Mrs. Lois S. TARBERT		Whiteford, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary Embolus and				15 min			
154X		Bilateral Lung abscesses				4 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Adenocarcinoma of Pectoral - 44				br. abd. m.			
		(c) intestinal obstruction and aspiration of vomitus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
Month, Day, Year 19									
21. I certify that I attended the deceased from 6/24, 1959, to 11 Aug., 1959, that I last saw the deceased alive on Aug. 4, 1959, and that death occurred at 920 M.D., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		W.H. SADOWSKY M.D.				DATE SIGNED 8/4/59			
PHYSICIAN'S NAME (Type)		504 Lewis St.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 7, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Emory Methodist Church Cem.		22d. LOCATION (City, town, or county) Forest Hill, R.D., Ady Rond, Harford Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		ADDRESS 13 Broadway & 15th Sts. BEL AIR, Maryland		24a. REC'D BY REGISTRAR DATE AUG 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Tamm			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09150

9170

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <i>Harfard</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Harfard</i>	
CITY (If outside corporal limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporal limits, write RURAL and give nearest town)	
TOWN <i>Bel Air</i>		24 YEARS		TOWN <i>Bel Air</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>115 Fulford Ave.</i>			STREET ADDRESS <i>215 Victory LANE</i> (If rural give location)		
3. NAME OF DECEASED (Type or Print) <i>OLIVER John Vogel Jr.</i>			4. DATE (Month) (Day) (Year) OF DEATH <i>August 29, 1959</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 19, 1918</i>	9. AGE last birthday yrs. <i>40</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ENGINEER</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Army Chemical Center</i>	11. BIRTHPLACE (State or foreign country) <i>Altcona, Pennsylvania</i>	
13. FATHER'S NAME <i>OLIVER J. Vogel, sr.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>YES</i> (If Yes, give war or date of service) <i>World War II</i>			16. SOCIAL SECURITY NO. <i>215-14-9459</i>	17. INFORMANT & ADDRESS <i>Mrs Dorothy R. Noonan Vogel 215 Victory LANE Bel Air, Md.</i>	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420. / IMMEDIATE CAUSE (A) acute myocardial infarction ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO (C) coronary A. atherosclerosis enlarged atherosclerosis</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
several years many years					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) <i>Bel Air</i> (State) <i>Md.</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>29 Aug. 1959</i> to <i>29 Aug. 1959</i> , that I last saw the deceased alive on <i>29 Aug. 1959</i> , and that death occurred at <i>0745P</i> M, from the causes and on the date stated above. SIGNATURE <i>Warren R. Leach M.D.</i> DATE SIGNED <i>29 Aug 1959</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			DATE THEREOF <i>Sept. 1, 1959</i>	NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial Gardens</i>	LOCATION (City, town, or county) (State) <i>Bel Air, Harf Co., Maryland</i>
24. REC'D BY REGISTRAR <i>SEP 1 '59</i>			REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Joseph W. Foster w. Broadway + Williams St Bel Air, Maryland</i>	

8) BROMITIAS-ITASCO DEMONSTRATION STATE CHARTER

ITASCO TO STATEMENT C.R.

ALL INFORMATION

CONTAINED HEREIN IS UNCLASSIFIED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9171 CERTIFICATE OF DEATH

09151
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Haure de Grace</i>		b. COUNTY <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>About 40 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Haure de Grace</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>902 Erie Street</i>		d. STREET ADDRESS <i>902 Erie Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Winfield</i>		First <i>Webster</i>	Middle <i>Webster</i>
4. DATE OF DEATH <i>Aug. 29, 1959</i>		Last <i>64 yrs.</i>	Month Day Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 7, 1895</i>	
9. AGE (In years lost birthday) <i>64 yrs.</i>		10. IF UNDER 1 YEAR Months <i>902 Erie St.</i>	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labover</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Stafford, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Philip Webster</i>		14. MOTHER'S MAIDEN NAME <i>Mary Frances Aikens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>219-01-4652</i>	
17. INFORMANT <i>Mrs. Mary Louise Webster, Haure de Grace, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Cerebral Hemorrhage</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <i>Hypertension</i>	
19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 10, 1959</i> , to <i>Aug. 29, 1959</i> , that I last saw the deceased alive on <i>Aug. 27, 1959</i> , and that death occurred at <i>10:10 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>229 Revolution St. Haure de Grace, Md. 8/31/59</i>	
ACTUAL SIGNATURE <i>George T. Stansbury, M.D.</i>		DATE SIGNED <i>8/31/59</i>	
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-2-1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Berkeley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Berkeley, Harford Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock, Haure de Grace, Md.</i>		ADDRESS RECD' BY REGISTRAR DATE <i>SEP 2 '59</i>	
		24. REGISTRAR'S SIGNATURE <i>Carling & Knapp</i>	

STATE OF TEXAS - DEPARTMENT OF PUBLIC SAFETY

STATE OF TEXAS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09152

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shore de Grace</i>		c. LENGTH OF STAY IN 1b <i>about 28 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>620 Freedom St.</i>		d. STREET ADDRESS <i>620 Freedom St</i>	
3. NAME OF DECEASED (Type or print) <i>Arthur C. Hetzel</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>1</i> Year <i>1959</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 20, 1884</i>
9. AGE (In years last birthday) <i>74 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	
11. BIRTHPLACE (State or foreign country) <i>West Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>217-01-8151</i>	
17. INFORMANT <i>Mrs. Dora Jenkins, Shore de Grace, Md.</i>		Address <i>553 Allaire St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Coronary Thrombosis</i>			
DUE TO <i>Arteriosclerotic Heart disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Osteomyelitis of Left Leg</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Churchville</i> (County) <i>Harford</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>June 10, 1959</i> , to <i>July 31, 1959</i> , that I last saw the deceased alive on <i>July 31, 1959</i> , and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>569 Revolution St. Shore de Grace, Md.</i> DATE SIGNED <i>8/3/59</i>			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 4, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Ashbury Cemetery</i>		22d. LOCATION (City, town, or county) <i>Churchville</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullork</i>		ADDRESS <i>Shore de Grace</i>	
24a. REC'D BY REGISTRAR DATE <i>AUG 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Elmer E. Bullork</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

STATE OF CALIFORNIA - BUREAU OF ESTATES
CERTIFICATE OF DEATH

or death: Page 4
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

TO HOSPITAL

may be referred

by the hospital or attending physician.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9173

Item 9 Film G246 8-24-59 et

09153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

HARFORD

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

MARYLAND CECIL ✓

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAVRE DE GRACE

c. LENGTH OF STAY IN 1b

9 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FERRYVILLE

07X-2

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Harford Mem. Hosp.

d. STREET ADDRESS

RD

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
FletcherMiddle
P.Last
Williams4. DATE
OF
DEATH
Month
August
Year
1959

5. SEX

Male

6. COLOR OR RACE

Wh. fe

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

12/27/95

9. AGE (In years
last birthday)

16/165

10. IF UNDER 1 YEAR
IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Raises mice for Research

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FRANK E. Williams

14. MOTHER'S MAIDEN NAME

Mary Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

176-20-2109 Harlan Williams

Address
14 East Parkway, Glen
Farms, Newark, DelINTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

154X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

Carcinoma of the Rectum
metastasis to the liver and
8 months

DUE TO

(c)

" "

to the common duct.

(d)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 8/17/59 to 8/16/59, that I last saw the deceased
alive on 8/16/59, and that death occurred at 10 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

Ostap Wolschuk

M.D. Harford Memorial Hospital

Harford Memorial Hospital

Harford Memorial Hospital

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

8-18-59

22b. DATE THEREOF

Hopewell cem.

22c. NAME OF CEMETERY OR CREMATORIUM

Port Deposit, Md. Rural

22d. LOCATION (City, town, or county)

(State)

FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE AUG 19 '59

24b. REGISTRAR'S SIGNATURE

Oscar S. Tamm

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9174

CERTIFICATE OF DEATH

09154

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bel Air</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford County Home</u>		MARYLAND LENGTH OF STAY (in this place) <u>2 years</u> STATE <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Joppa</u> STREET ADDRESS <u>1</u> (If rural give location)	
3. NAME OF DECEASED (First) <u>Samuel</u> (Middle) <u>Edward</u> (Last) <u>Williams</u> (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH <u>August 25</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 8, 1900</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Williams</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Clark E. Fitzpatrick, Bel Air, Md.</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic cardio-vascular disease</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 20, 1957, to Aug. 25, 1959, that I last saw the deceased alive on Aug. 21, 1959, and that death occurred at 4:00 AM, from the causes and on the date stated above. SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Maryland</u> DATE SIGNED <u>August 25, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial removal</u>		DATE THEREOF <u>Aug. 25, 1959</u> NAME OF CEMETERY OR CREMATORIUM <u>Maryland University</u> LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
DATE <u>AUG 27 '59</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard W. Hudson</u> ADDRESS <u>Abingdon Ave.</u>	

